STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBORO HILLS NURSING HOME	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard survey and abbreviated surveys were conducted from 06/22 - 06/24/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having an opportunity to correct before remedies would be recommended for imposition. Investigated were KY14493, KY14466, KY14534, KY14670, KY14671, and KY14806 and found to be unsubstantiated.	F 000	Brownsboro Hills acknowledges receipt of the statement of deficiencies. The response to this statement of deficiencies and Plan of Correction does not constitute any admission that any deficiencies are accurate. The Plan of Correction is submitted as a written allegation of compliance.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide Peripherally Inserted Central Catheter (PICC) line services by qualified licensed persons, in accordance with physician orders and policy for one (1) out of thirty-two (32)sampled residents (#12), related to flushing, measurement of mid arm circumference and measurement of external catheter length of PICC line. Staff failed to implement the policy and describe appropriate techniques to assure proper PICC care was provided. The facility failed to obtain initial PICC	F 328	It is the facilities policy to be in compliance with this regulation. 1) Resident # 12 has completed the PICC line therapy and line has been discontinued. 2) No other residents in the facility have a PICC line, therefore no other residents were effected by this practice. 3) The Nursing Management Staff has been reeducated on PICC Line Policy and Procedures by the Regional Quality Specialist. Licensed Staff have been reeducated on PICC Line Policy and Procedures by the DON and ADON. Licensed Staff have completed return demonstrations on the following: Peripherally Inserted Central Catheter (PICC) Dressing changes. (PICC) measurement of arm circumference and external catheter length and (PICC) flushing. The DON/ADON will QI monitor PICC Line documentation and dressing changes (to include measuring) weekly X's 4 weeks, then monthly X's 3 months then quarterly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

X Marianne Nell — X Administrator — X 7/16/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING _____ B. WING _____	06/24/2010

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F 328	Continued From page 1 measurements of arm circumference or external catheter length when Resident #12 was transferred in from another facility. The findings include: The facility policy for Peripherally Inserted Central Catheter (PICC) flushing, states that instilled flushing agent using pulsing (start/stop) technique while observing for signs of complication/infiltration. The policy also states that length of eternal catheter and upper arm circumference (3 inches or 10 centimeters above insertion site) is obtained: Upon admission, during dressing changes and if signs or symptoms of complications are present. Review of Resident #12's medical record revealed that on 06/11/10 the resident had a left upper extremity PICC for IV antibiotic therapy. Furthermore the medical record revealed this thirty (30) year old was transferred from another healthcare facility to this facility on 06/15/10 with a diagnosis of Stage IV right ischial ulcer along with a PICC line for IV antibiotics. Observation on 06/24/10 at 10:40am revealed Licensed Practical Nurse (LPN) #4 flushed the PICC line with 5ml of normal saline in a continuous motion. After the PICC line flush, LPN #4 related that Resident #12's PICC dressing change was done on 06/23/10. However, on 06/24/10 at 10:45am, LPN #4 had prepared to re-change the PICC dressing due to forgetting to measure the arm circumference and external length on 06/23/10. Upon returning LPN #4 measured arm circumference and external catheter length without removing prior PICC line dressing upon the recommendation of the	F 328	4) The findings will be reviewed in the RM/QI process monthly X's 3 months then quarterly to ensure residents receive proper treatment and care as it relates to PICC Lines.	07/14/2010

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F 328	Continued From page 2 Director of Nursing (DON), Assistant Director of Nursing (ADON) and LPN Unit Manager. LPN #4 measured the left upper arm circumference width as sixteen (16) inches and the external length six (6) inches. Interview conducted with LPN #4 at 11:00 am, revealed the LPN thought the technique to flush a PICC line was to be done in a continuous flushing motion and to stop if resistance is met. The measurement of the arm circumference is done by measuring around the arm and the measurement for the external catheter length is done by measuring from the entry point to the blue tip. Interview with the LPN Unit Manager at 11:30am revealed that flushing a PICC line is to be done in a continuous flush. The measurement of the arm circumference is done by measuring right above the PICC entrance. The measurement of the external catheter length is from the insertion site to the start of the hep-lock cap. Interview with the ADON at 1:45am revealed that the measurement of the arm circumference is done by measuring approximately midway above the entry point and the measurement of the external catheter length would start at the insertion entry point to the start of the hep-lock cap. Interview with the DON at 12:00pm revealed that flushing a PICC line is done in a continuous flush and to stop for resistance. The measurement of the arm circumference is done by measuring above the site. The measurement of the external catheter length would start at the point of entry and to hep-lock cap. Also, the DON revealed that	F 328		

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F 328	Continued From page 3 training had been conducted per policy 6.3 Peripherally Inserted Central Catheter (PICC) Flushing, on 03/04/10 and 03/05/10 which included LPN #4, the LPN Unit Manager, ADON and DON.	F 328		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	It is the facilities policy to be in compliance with this regulation. 1) Resident # 1 was not affected by this practice. The treatment cart was removed from the resident's room and was cleaned and sanitized the whole cart inside and outside. Nurse # 2 was reeducated on Infection Control and placed on 2-day suspension for violation of Infection Control Policy. 2) Facility residents had the potential to be affected by this practice. Other Treatment carts were cleaned and sanitized. 3) Licensed nurses have been reeducated on Infection Control Practices as it relates to treatment carts and dressing changes. The DON/ADON will QI monitor dressing changes/treatments and the placement of treatment carts weekly X's 4 weeks, then monthly X's 3 months and then quarterly.	

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F 441	Continued From page 4 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined the facility failed to ensure dressing changes were completed to prevent contamination for one (1) resident (#6) of thirty-two (32) sampled residents. The facility failed to assure treatment supplies were handled in a sanitary manner and failed to clean a soiled resident prior to a clean dressing change of a sacral wound. The findings include: Record review for Resident #6 revealed an admission date of 05/13/10 and diagnoses of Osteomyelitis and Removal internal fixator device. Review of the Admission MDS dated 05/25/10 revealed the resident had two stage IIs and two stage IVs. In addition, physician orders dated 03/29/10 indicted the resident was experiencing pain due to Left hip Osteomyelitis due to a prothesis removal. The orders also indicted the resident was sent to the hospital on 06/18/10 for evaluation of the left hip due to increased drainage. The physician orders indicated the resident was to receive an antibiotic Tygacil 50mg IV every 12 hours indefinitely. Observation of the resident's dressing change with LPN #2 (Licensed Practical Nurse) on 06/23/10 at 11:20am revealed the LPN brought the entire treatment cart into the resident's room	F 441	4) The findings will be reviewed in the RM/QI process monthly X's 3 months then quarterly to ensure the facility maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	07/14/2010

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F 441	Continued From page 5 up to the bed side. The LPN then proceeded to prepare the equipment needed for the dressing changes. After completing one dressing change the LPN requested assistance with the rest. The Unit Manager entered the room to assist with the dressing change and instructed the LPN to remove the treatment cart immediately from the room. The Unit Manager proceeded to assist by holding the resident over for access to the left hip and sacral area. It was noted the resident was wearing a brief that was untapped and laid flat on the bed. The brief was heavily soiled with feces. The LPN proceeded to remove the dressing, clean the wound and apply the clean dressing to the sacral wound. The LPN then replaced the soiled brief over the clean dressing. Interview with the Unit Manager on 06/23/10 at 11:30am revealed it was an infection control issue having the treatment cart in the room as it would contaminate the cart. It was a standard of practice to not bring the treatment cart into a resident's room. Interview with LPN #2 on 06/23/10 at 2:30pm revealed he removed the treatment cart from the room because the Unit Manager said it was wrong, and an infection control issue. The LPN indicated he did not understand as the inside of the cart was clean and the outside was dirty anyway. The only reason the cart was taken into the room was because the resident had so many items to use and he was only one person. The LPN was not sure what the Policy and Procedure manual instructed to do in this case; however, the Unit Manager instructed him to wash down the cart on the outside. The LPN further indicated the resident was cleaned up after the dressing was changed and then he had to re-do the dressing	F 441		

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F 441	Continued From page 6 change again. The LPN indicated the resident should have been cleaned up first before the dressing change took place as the soiled brief contaminated the clean dressing. Interview with the Director of Nursing (DON) revealed staff are not supposed to take the cart into the resident room as it is a violation of infection control standards. Nurses were in-serviced and received information that this leads to cross contamination issues. The DON further stated replacing the dirty brief on the resident after a clean dressing change was an unacceptable practice.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure circuit breaker boxes were locked to prevent resident access on all six (6) halls. The findings included: Observations of Halls A, B, D, E and F on 06/23/10 at 2:30pm revealed there were only slide locks on the circuit breaker boxes on the halls. Observation of Hall C revealed there was no slide lock or any other lock on the circuit breaker. Interview with the Maintenance Director on 06/23/10 at 4:40pm revealed he was aware there	F 456	It is the facilities policy to be in compliance with this regulation. 1) No resident was affected by this practice. 2) Facility residents had the potential to be affected by this practice. 3) Circuit breaker boxes on halls A,B,C,D,E and F have all had pad locks placed on them. The Maintenance Department has been reeducated on the safety of equipment and the need to ensure circuit boxes remain locked at all times. The Administrator /Designee will QI monitor circuit breaker boxes to ensure they remain locked at all times.	

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F 456	Continued From page 7 should be a lock in place on the circuit breaker but he had been trained at another facility that it was acceptable to have slide locks on circuit breaker. The Maintenance Director further stated there needs to be a lock on the circuit breaker so residents do not have access. Residents who have access to a circuit breaker box could cut off electrical equipment for another resident, (example oxygen tank). Interview on 06/24/10 at 1:50pm revealed the Maintenance Director was not aware it was a state requirement. Interview with the Administrator on 06/24/10 at 10:25am revealed you do not want residents getting into the circuit breaker and that residents may harm them self or others if residents have access to circuit breaker. The facility could not provide a policy on locking the circuit breaker or a system for maintaining circuit breaker boxes.	F 456	4) The findings will be reviewed in the RM/QI process monthly X's 3 months then quarterly to ensure essential equipment is maintained in a safe operating condition.	07/14/2010

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	185348	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/07/2010

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on 07/07/10. The facility was found not to meet the minimal requirements with 42 code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "D."	K 000	Brownsboro Hills acknowledges receipt of the statement of deficiencies. The response to this statement of deficiencies and Plan of Correction does not constitute any admission that any deficiencies are accurate. The Plan of Correction is submitted as a written allegation of compliance.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that a hazardous area was protected according to NFPA standards. The findings include: Observation on 07/07/10 at 12:36pm revealed the maintenance shop door did not have a self closer. The Maintenance Director was present during the observation. Interview on 07/07/10 at 12:36pm, with the	K 029	It is the facilities policy to be in compliance with this regulation. 1) No residents were identified to have been affected by this practice. The Maintenance door now has a self- closure on the door. 2) Facility residents had the potential to be affected by this practice. Facility doors have been inspected to assure self-closures are in place. 3) Maintenance Department has been reeducated in the Comprehensiveness of the Life Safety codes pertaining to self-closures on doors. Maintenance Department will QI monitor on a monthly bases and fix or place self-closures on any identified doors.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marianne Wells	Administrator	July 29, 2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 Maintenance Director, revealed the door had never had a self closer. Reference: One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	4) The findings will be reviewed in the RM/QI process monthly X's 3 months then quarterly to ensure Life Safety codes pertaining to self-closures.	07/28/2010
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain a sprinkler system according to NFPA standards. The findings include: Record review on 07/07/10 at 12:03pm, revealed the facility failed to have an interior pipe inspection performed on the sprinkler system since 2003.	K 062	It is the facilities policy to be in compliance with this regulation. 1) No residents were identified to have been affected by this practice. The sprinkler pipe's interior has been inspected and passed as to be in satisfactory condition. 2) Facility residents had the potential to be affected by this practice. The interior pipe of the sprinkler system has been inspected and passed with satisfactory condition.	

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K 062	Continued From page 2 Interview on 07/07/10 at 12:03pm, with the Maintenance Director, revealed that he had planned to have it performed the next time the system was checked. Reference: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	3) Maintenance Department has been reeducated in the Comprehensiveness of the Life Safety codes pertaining to the inspection of interior pipes on the sprinkler system. Maintenance Director will add that the system be inspected every three years, to the preventative maintenance program. 4) The findings of the interior pipe inspections will be reviewed in the RM/QI process to ensure Life Safety codes pertaining to inspection of interior pipes on the sprinkler systems.	07/28/2010